

**Traumatic Brain Injury Waiver Program
Case Management Initial Contact Log**

Applicant:

Last Name_____ First Name_____ MI_____

Date Case Manager received notification from APS Healthcare of applicant selection

Date of Initial Contact_____ (Circle one only) Face to face/Telephone
(Initial contact must occur within three days of notification from APS Healthcare, Inc.).

Case Manager Signature_____ Date_____

Financial eligibility determination

The Case Manager must submit a TBI DHS-2 form to the county DHHR office to determine financial eligibility within sixty (60) calendar days from the date the case management agency or the applicant receives the notification of selection letter.

Date Financial Eligibility Initiated by submitting TBI DHS-2 form_____

Date APS Healthcare, Inc. was notified that the financial eligibility process was initiated:_____

Once an applicant has been found medically and financially eligible, the Case Manager must request Member Enrollment from APS Healthcare, Inc. by completing a Member Enrollment Request form.

Date Member Enrollment Request form was submitted to APS Healthcare, Inc.:

Case Manager Signature_____ Date_____

Comments:_____

Member:

Member Enrollment Date_____

(Member Assessment must be completed within 7 calendar days of Member Enrollment).

Date of Case Manager's Scheduled Home Visit for Member Assessment_____

(Initial Service Plan Meeting must be scheduled within 7 calendar days of the Member Assessment).

Date of Case Manager's Scheduled Initial Service Plan Meeting_____

Interim Service Plan Implemented? (Only for members who require immediate services.) ☐ Yes ☐ No

Case Manager Signature _____ Date _____

Comments: _____

Seven (7) Day Contact:

Date direct care services began _____

Date of Case Manager's follow up contact _____

(Circle one only) Face to face/Telephone

(Must be completed within 7 days of date direct care services began).

Comments: _____

Case Manager Signature _____ Date _____